HEALTH FINANCE COMMISSION

Legislative Services Agency
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MEETING MINUTES[1]

Meeting Date: August 15, 2007
Meeting Time: 1:00 P.M.
Meeting Place: State House, 200 W. Washington St., Senate Chambers
Meeting City: Indianapolis, Indiana
Meeting Number: 2

Members Present: Sen. Patricia Miller, Chairperson; Sen. Gary Dillon; Sen. Beverly Gard; Sen. Vaneta Becker; Sen. Connie Lawson; Sen. Ryan Mishler; Sen. Vi Simpson; Sen. Sue Errington; Rep. Charlie Brown, Vice-Chairperson; Rep. Peggy Welch; Rep. John Day; Rep. Carolene Mays; Rep. Scott Reske; Rep. Timothy Brown; Rep. Suzanne Crouch; Rep. Richard Dodge; Rep. David Frizzell; Rep. Don Lehe.

Members Absent: Sen. Marvin Riegsecker; Sen. Earline Rogers; Sen. Connie Sipes; Rep. Craig Fry; Rep. Phil Hoy.

Sen. Patricia Miller called the second meeting of the Health Finance Commission to order at about 1:05 pm.

Survey Process for Long-Term Care Facilities

Mr. Terry Whitson, Assistant Commissioner for Health Care Regulatory Services, Indiana State Department of Health (ISDH), distributed a document entitled "Strategic Plans for 2007" detailing strategic planning and program development activities that the ISDH is undertaking for 2007 (see

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.in.gov/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

Exhibit #1). The document addresses the following topics: (1) improving the survey process, (2) ongoing Centers for Medicare and Medicaid Services (CMS) quality-of-care initiatives, and (3) ISDH healthcare quality-of-care initiatives.

Mr. Whitson described the purpose of licensing and certification as being to promote and ensure quality of care in long-term care facilities. The regulations are established primarily by CMS. The ISDH serves as the state survey agency for all federal certification programs in acute and long-term care. CMS regularly conducts oversight and look-behind surveys to evaluate the state's performance with the challenge being to balance the evaluation of quality of care with maintaining a survey process that is the least intrusive on facilities.

Mr. Whitson added that the ISDH and CMS develop and implement initiatives designed to improve quality of care. The Government Performance and Results Act (GPRA) of 1993 was adopted to analyze and improve outcomes of government programs. The two GPRA goals established for CMS Region V concern pressure ulcers and restraints.

Mr. Whitson outlined ISDH initiatives to address pressure ulcers and restraints, which include the October 30 Leadership Conference focusing on pressure ulcers; a possible initiative to assist health facilities in the purchase of pressure-reducing devices and to reduce pressure ulcers based on the New Jersey best practices initiative; and the March 2008 Leadership Conference focusing on behavior management and restraints.

Regarding "immediate jeopardy" findings on surveys, Mr. Whitson stated that CMS Region V has a higher incidence of immediate jeopardy findings than other regions. Wisconsin has the highest incidence of immediate jeopardy findings in the region with Indiana second. Mr. Whitson added that Indiana has ranked 5th through 10th nationally in immediate jeopardy findings in recent years. The term "immediate jeopardy" is a CMS term and refers to an event where serious harm occurred or a high potential for serious harm exists. CMS reviews all state findings of immediate jeopardy and has not found any Indiana determinations to be in error. CMS federal surveyors have called several of the immediate jeopardy findings at Indiana nursing homes. Mr. Whitson also provided examples of immediate jeopardy findings.

Mr. Whitson also described some initiatives on quality of care and the survey process, which include meeting with the long-term care provider associations monthly to identify concerns and develop a response. The ISDH is also working with the Indiana Department of Administration to conduct events to improve efficiency and effectiveness of agency activities. The Division of Long-Term Care recently completed its first event of this kind. The ISDH is also implementing conferences and newsletters that will provide best practices to providers.

In response to questions, Mr. Whitson stated that his agency has a 10% to 15% vacancy rate, and they try to hire surveyors who already have some familiarity with long-term care services. And with some nursing homes that have multiple locations and facilities, it is sometimes difficult to not have surveyors with previous employment experience in a facility that they will be surveying.

In response to a question regarding differences between regions in the surveying process and results, Mr. Whitson stated that there can be different interpretations of the rules, but, although never entirely able to eliminate, the ISDH tries to reduce the disagreements between the facilities and the surveyors.

In response to a concern that some violations are for things that are not patient-oriented or related, Mr. Whitson stated that there is a broad range of survey items, but ISDH and the surveyors cannot pick and choose what they will report on. Mr. Whitson added that there are a lot of facilities with no problems at all.

In response to a question as to what needs to be done to improve the survey process, Mr. Whitson responded that the biggest problem is an inconsistency between surveyors; however, it can take a couple of years for a surveyor to become comfortable with the nursing facility regulations, and a high turnover rate makes it even more difficult. Mr. Whitson added that nursing facilities should be aware of what needs to be done, but nursing facilities also have high turnover rates for their employees.

Ms. Arlene Franklin, State Long-Term Care (LTC) Ombudsman, stated that she is not representing the Family and Social Services Administration (FSSA); rather she is speaking on behalf of residents of comprehensive care and residential care facilities. As the State LTC Ombudsman, she supervises 22, mostly part-time, local LTC ombudsmen. Ms. Franklin stated that the ombudsmen are often frustrated for several reasons:

(1) The citations by ISDH seem to be less severe than situations call for.
(2) The ISDH can only use documentation kept and provided by facilities; they cannot cite based on oral statements or documentation provided by consumers or their advocates.
(3) Many complaints are substantiated but not verified, resulting in no citation being issued.
(4) Complaint surveys sometimes show that facilities fail to follow through with their written plans to correct problems.
(5) The survey system fails to support resident rights when those rights conflict with a facility's idea of safety.

Ms. Franklin stated that the ombudsmen do not support any weakening of the survey system, which already uses facility input and documentation to a much greater extent than consumers' input in investigations and citations.

Ms. Faith Laird, Indiana Health Care Association (IHCA), provided two documents to the Commission: (1) one entitled "Concerns with the Indiana State Department of Health Survey, Certification and Enforcement Process" (see Exhibit #2); and (2) a grid entitled "Scope and Severity Matrix" (see Exhibit #3).

Ms. Laird stated that there has been a large increase in the scope and severity of deficiencies in Indiana over a two-year period; there has been a disparity in survey statistics in comparison to contiguous states, to other states in the same region, and to the United States; and there has been an increase in scope and severity despite CMS quality care measures that are in line with or better than national scores, such as in restraint use, pressure sores, pain, and other measures.

Ms. Laird also provided various comparison statistics and the following recommendations:
(1) Commission an independent review of the survey process in Indiana.
(2) Continue ongoing educational joint training of providers and surveyors.
(3) Institute a corrective action process for surveyors who are found to have exhibited a deficient practice; identify and take measures to ensure that the deficient practice does not recur; require monitoring by key staff at the ISDH to ensure that solutions are sustained.

Mr. Jim Leich, Indiana Association for Homes and Services for the Aging, stated that he has been hearing from his members that problems associated with the surveying process have reached a level that needs to be addressed. Most of all, the industry needs a fair and consistent surveying system. Mr. Leich added that some of the problems are that remedies applied in Indiana vary with other states and the country; and there are significant differences between regions in terms of levels of violations.

In responding to a question about the length of time surveyors spend in a facility, Mr. Leich indicated that the survey process is disruptive, and the average cost per bed to do a survey and how Indiana compares to other states is important.

In responding to a question regarding a possible "gotcha attitude" by surveyors, Mr. Leich indicated that he believes things have definitely changed for the worse over the last 12 to 18 months.

In responding to a question, Mr. Leich stated that the focus in Indiana should be on consistency of process; and the survey process and regulatory system hinders movement toward resident-selected care and resident choice.

Mr. Robert Decker, representing Hoosier Owners and Providers for the Elderly, also stated that no one doubts that there is a consistency issue. Mr. Decker made the following suggestions:

(1) The state should perform a process analysis and evaluation regarding consistency and then live with the results.
(2) The state should continue the joint training and leadership conferences, which allows everyone to talk to each other and discuss best practices.
(3) ISDH should look at surveyor staff management and disciplinary processes.
(4) There should be continued use of the Civil Monetary Penalty fund to address deficient practices.

In response to a question as to whether there is a public policy issue that needs to be dealt with legislatively or whether it is an issue that the industry and the ISDH should work out together, Mr. Decker recommended an independent evaluation of the survey process be conducted and funded from the nursing facility fines. As to whether this fund can be used for this purpose, Mr. Whitson responded that the ISDH would need to study that question and would report back to the Commission at a later time.

Ms. Robyn Grant, Long-Term Care Policy Director with United Senior Action, stated that her organization is a statewide senior citizen advocacy organization representing over 14,000 members. Ms. Grant stated that it is her observation that when the ISDH cites a facility for an "immediate jeopardy" situation, it is an appropriate determination. She added that from a consumer perspective, the ISDH should be commended rather than criticized.

Ms. Grant also stated that residents and families have their own concerns about the survey process:
(1) Far too few deficiencies are actually cited; and when ongoing problems are reported to surveyors, nothing happens.
(2) When deficiencies are actually cited, their seriousness or level of severity is frequently discounted.
(3) Annual surveys do not give a true picture of nursing home conditions because nursing homes have geared up and prepared for the survey in advance and the timing of surveys is much too predictable.
(4) Many consumers have an overwhelming sense that the system is stacked against them due to a fear of retaliation against themselves or a loved one for reporting a problem. In addition, nursing facilities have appeal rights, and consumers have no rights to challenge the findings or lack of findings.

Ms. Grant provided two recommendations:

(1) Continue to gather information about the consumer perspective.
(2) Involve consumers just as much as providers in developing any proposed changes to the survey process.

In response to a question, Ms. Grant indicated that there is a fear of retaliation on the part of residents and their families.

ISDH Update on Regulations for Birthing Centers and Abortion Clinics

Mr. Whitson also updated the Commission on birthing centers and abortion clinics. Regarding birthing centers, Mr. Whitson stated that the ISDH began licensing birthing centers in February 2006. Two birthing centers, one located in Muncie and the other in Indianapolis, applied for a license and were subsequently inspected and licensed.

However, Mr. Whitson indicated that the ISDH is aware of at least one unlicensed birthing center, in Topeka, Indiana, which is run by Amish providers and does not wish to be licensed. The statute requires all birthing centers to be licensed with no exceptions. Mr. Whitson stated that in discussing with various legislators, the primary intent of the licensing requirement was to provide Medicaid funding, which requires that a facility be licensed. The ISDH has not taken any action against unlicensed birthing centers pending resolution of whether there should be an exception for religious-based centers.

Regarding abortion clinics, Mr. Whitson stated that, as provided for in statute, the ISDH began licensing abortion clinics July 1, 2006. The ISDH received nine license applications, all of which have had at least one inspection by ISDH nurse surveyors and have fulfilled the licensing requirements and been issued a license.

Mr. Whitson added that the licensing of abortion clinics has achieved positive results. Abortion clinics tended to be run similar to physician offices in that there were unwritten policies and procedures. The licensing process has resulted in improved communication systems and procedures related to patient care and facility operation.

ISDH Report on Implementation of Adverse Event Reporting

Mr. Terry Whitson, ISDH, stated that the preliminary medical errors report for 2006 was issued March 6 with the final report to be issued in late August.

Mr. Whitson added that the ISDH is conducting long-term care leadership conferences to address patient safety and quality of care issues. The first conference in June 2007 addressed the falls problem.

Mr. Whitson indicated that in the past year there have been new or more formalized patient safety coalitions developed. These coalitions serve an important role in finding solutions to adverse events. The operational centers include the following patient safety centers: Michiana Coalition, Indianapolis Coalition, Evansville Coalition, and the Hospital/Long-Term Care Coalition. The Patient Safety Organizations and the Patient Safety and Quality Improvement Act of 2005 allows the development of patient safety centers. Final regulations are expected to be issued by the U.S. Dept. Of Health and Human Services in the near future.

The National Quality Forum is in a comment period on proposed consensus standards for infection rate reporting. Mr. Whitson stated that he is hopeful that there will be consensus standards in

place by the end of 2007.

Regarding the Implementation of SEA 207 on quality indicators, Mr. Whitson stated that the ISDH is awaiting final federal regulations to be issued on patient safety centers. The ISDH will be issuing a request for proposals pursuant to the statute to select an agency to coordinate quality indicators. The ISDH expects to issue the RFP this fall.

Indiana Tobacco use Prevention and Cessation Program Effectiveness and Potential Transfer to ISDH

Ms. Karla Sneegas, Executive Director of the Indiana Tobacco use Prevention and Cessation (ITPC) Program, provided a slide presentation (see Exhibit #4) describing outcomes and the effectiveness of Indiana's tobacco prevention and cessation program. Ms. Sneegas described the recommended interventions of Centers for Disease Control and Prevention (CDC) guide to community preventive services as preventing tobacco product use initiation, reducing exposure to secondhand smoke, and increasing cessation. Ms. Sneegas described Indiana's three-fold strategy as smoke-free air policies, higher cigarette prices, and sustained comprehensive community-based tobacco control programs for the goals of prevention and cessation.

Ms. Sneegas described the metrics used by ITPC and provided various statistics associated with the prevalence of adult and youth smoking, proportion of tobacco-free school districts, proportion of smokers making an attempt to quit, number of calls to the quitline, proportion of adults working indoors who report a smoke-free workplace, number of Hoosiers protected from secondhand smoke through local ordinances, and the percentage of grantees that submit quarterly reports on time.

Ms. Sneegas also distributed a copy of "Our Way to a Healthier Indiana: 2006-2007 ITPC Annual Report" (see Exhibit #5).

In response to a question regarding the absence of information on the direct effect from this program, Ms. Sneegas responded there is anecdotal evidence; and the ITPC has been involved with 80% to 90% of the school and hospital policy changes and 100% of the community actions.

Ms. Peggy Vols, local coordinator in Bartholomew County, stated that she has been involved with the ITPC from the beginning as an executive board member for four years, and she believes that ITPC is accomplishing the goals as mandated by the state legislature in 2000 and as set forth by IC 4-12-4-4.

Ms. Vols added that Bartholomew County has worked diligently building relationships and partnerships with 22 other agencies with the guidance and training and excellent leadership from ITPC. Ms. Vols stated that this same type of collaborative effort is happening throughout the state.

Ms. Vols added that the ITPC is operating very professionally by the CDC Best Practices Guidelines, and by focusing only on tobacco, ITPC can sink all their efforts into lowering the use of tobacco, thereby improving the health status and economic status of Indiana. Furthermore, ITPC is working efficiently and making significant strides at the grass roots level.

Ms. Vols concluded by stating that she supports ITPC remaining a separate agency of the government.

Dr. Judith Monroe, Commissioner of ISDH, stated that as state health commissioner, she is committed to decreasing the use of tobacco in Indiana and she wants to work productively with everyone who supports that goal. Dr. Monroe added that she is currently the chair of the ITPC Board, and ISDH has a good working relationship with ITPC.

Dr. Monroe stated that whether ITPC should come under ISDH has both pros and cons. She stated that, currently, ISDH and the ITPC are working well together and she would not want to see the momentum interrupted. However, tobacco is the number one preventable public health problem, and the ten states with the lowest smoking rates have tobacco prevention and cessation under their state health departments. There are potential savings in administrative costs and synergy with other ISDH programs that might be realized if the agencies were combined.

Dr. Monroe added that if the General Assembly were to move ITPC under the ISDH, she recommends that the ITPC should be constructed similar to the Office of Women's Health, which is legislatively mandated and cannot be abolished without legislative action and the Office of Women's Health has an advisory board. She added that the trust fund should be maintained, and Indiana's commitment to sustainable funding for an evidence-based comprehensive tobacco control program should be supported.

In response to a question on the possible administrative savings, Dr. Monroe stated that the ISDH already has a legal department, a grants department, and a financial department that could do some of administrative activity currently also being done in the ITPC. Dr. Monroe also indicated that the ISDH would continue the function of going into the communities and working with local groups, and the local coalitions should probably be continued rather than being administered by local departments of health.

Ms. Danielle Patterson, Senior Advocacy Director of the American Heart Association, stated that, while recognizing that much of the discussion will focus on whether the ITPC should remain an independent agency or be incorporated into the ISDH, the American Heart Association believes that the conversation should be focused on a bigger issue. She stated that, while the ITPC is currently funded at over $16 million, more than 38% of Indiana communities are now covered by some type of smoke-free law, and the tobacco excise tax has recently been increased, Indiana has yet to fully commit to the recommendations of the CDC to fund the program above $34.5 million. She added that if the ITPC is transferred to the ISDH, then the legislature should commit to using the tobacco prevention, control, and cessation funding for its intended purposes, and a commitment must be made to continue to use the science of the CDC's Best Practices for Comprehensive Tobacco Control Program and other proven research practices. Ms. Patterson also stated that the American Heart Association will continue to support the work of the ITPC and the ISDH. (See Exhibit #6 for Ms. Patterson's statement.)

Statewide Prohibition Against Smoking in Public Places

Dr. Enrico Garcia, member of the Indiana State Medical Association and president of the Indiana Association of Public Health Physicians and Local Health Department Organizations, Inc., stated that medical professionals and public health officials are very concerned with the detrimental effects of tobacco, be it primary or secondary, on the health of Indiana citizens. Based on research, smoking is the single most preventable cause of death and disease in the country and the state, higher than alcohol, AIDS, car accidents, illegal drugs, murders, and suicides, combined. Dr. Garcia added that smoking kills 10,300 Indiana citizens per year with a direct health care cost of $2 billion annually on the state.

Dr. Garcia stated that 75% of Indiana citizens are nonsmokers and that they should be protected from the pollution caused by the smoking minority. He added that he was in support of a smoke-free Indiana that would promote, preserve, and protect the health and well-being of our citizens.

Ms. Cathy Callaway, National Government Relations Department of the American Cancer Society, provided an overview of the smoke-free trend in the nation. Ms. Callaway described the problems associated with secondhand smoke and how it can cause or exacerbate a wide range of health problems.

Ms. Callaway provided a handout entitled "Smoke-free Trend Gains Momentum Throughout U.S." (see Exhibit #7). The document provides charts showing the cumulative number of municipalities adopting local clean indoor air laws between 1985 and 2007; municipalities with local 100% smoke-free laws between 1990 and 2007; a nationwide summary of statewide smoke-free laws; and other national smoke-free policy statistics.

Ms. Callaway stated that in 1995 California was the first to pass a strong statewide smoke-free law, and today there are 24 states and Washington, DC, that have enacted such laws. Ms. Callaway listed AZ, DE, HI, MA, NJ, NY, OH, PR, RI, WA, and DC as having laws covering all workplaces, including restaurants and bars; CA, CO, CT, ME, NM, and VT as covering restaurants and bars; FL, LA, MT, NV, and UT as covering workplaces and restaurants; ID as covering restaurants; and SD and ND as covering non-hospitality workplaces. She added that none of the state laws highlighted include ventilation or smoking rooms. Ms. Callaway added that the American Cancer Society would oppose legislation that included ventilation or smoking rooms.

She stated that research published in leading scientific journals has consistently and conclusively shown that smoke-free laws have no adverse economic effects on the hospitality industry. She also stated that the American Cancer Society encourages the Health Finance Commission to endorse a comprehensive smoke-free law that protects everyone's right to breathe smoke-free air.

Ms. Callaway also distributed "The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General," published by the U.S. Department of Health and Human Services (see Exhibit #8).

A comparison of Indiana cities' and counties' smoke-free ordinances was distributed in members' packets (see Exhibit #9).

Ms. Danielle Patterson, American Heart Association, distributed a statement describing facts about heart disease in Indiana and how banning smoking in public places can positively affect health outcomes related to exposure to secondhand smoke (see Exhibit #10). The statement also referred to studies that show smoke-free laws are associated with reductions in particulate matter in restaurants and bars, reductions in secondhand smoke exposure for restaurant and bar workers, and improvements in respiratory and sensory symptoms and pulmonary function among these workers. The statement concluded by stating that the American Heart Association encourages the Health Finance Commission to protect the rights of all citizens of Indiana and recommend a comprehensive smoke-free law.

Ms. Debra Salefski, a radiation therapist in Hamilton County, stood in support of a statewide smoke-free law that would make all public places and worksites smoke-free. Ms. Salefski stated that, as a radiation therapist, she personally works with cancer patients and has provided

treatment for a number of lung cancer patients through the years who have never smoked, but suffered from lung cancer due to secondhand smoke. She urged the Health Finance Commission to support a statewide smoke-free law for all Indiana residents.

Ms. Salefski also distributed a statement from Ms. Patricia Ells, Government Relations Manager for the American Cancer Society, which described the three critical tools for reducing tobacco usage as (1) passing a high tobacco tax, (2) passing a comprehensive smoke-free air law, and (3) adequately funding tobacco cessation and prevention programs to help current smokers quit and keep others from starting. The American Cancer Society supports the recommendations of the CDC Best Practices and hopes that the state will continue to increase funding until the state reaches CDC-recommended levels (see Exhibit #11).

Ms. Cassy Denny, student, spoke in support of banning smoking in public places.

Dr. Judith Monroe, ISDH, also indicated support for a statewide prohibition against smoking in public places.

Dr. Terrell Zollinger, Indiana University School of Medicine, spoke of his study to estimate the economic impact of secondhand smoke by looking at the health care costs and loss of like costs associated with diseases caused by secondhand smoke exposure. Dr. Zollinger stated that secondhand smoke causes low birth weight babies, SIDS, lower respiratory infections in kids, asthma induction or exacerbation, middle-ear infection in kids, lung cancer, heart disease mortality, and nasal sinus cancer. He estimated that health care costs for adults for hospitalization alone totals $6.2 million, health care costs for children totals $10.5 million, loss-of-life costs for adults totals $19.2 million, loss-of-life costs for children totals $20.3 million, costs for Marion County totals $53.9 million (in 2000 dollars), and costs for Indiana totals $486.7 million (in 2007 dollars) (see Exhibit #12).

Reimbursement Rates to Providers and the Premium Costs of Accident and Sickness Insurance Policies and HMO Contracts

Dr. Theresa Lubbins, physician, provided data on her costs of operating a physician's office. She stated that she charges $83 for an office visit for a patient with a new problem requiring prescription medication, typically requiring 15 minutes. Of this amount, the typical overhead for a primary care office is between 40% and 60%. Consequently, of the $83, approximately $50 is for staff, building, supplies, and liability insurance. Medicaid has historically reimbursed at $25.98 for this code.

She provided another example of a $121 charge for a wellness visit for a child under the age of one year, covering a developmental screen, educating the parent, and a complete exam. At 60% for overhead, the cost of overhead is approximately $73. Dr. Lubbins stated that Medicaid reimburses at $53.65.

Dr. Lubbins added that with doctors facing up to $175,000 in student loans for their education, many are becoming more business savvy. She stated that doctors have previously used payments from commercial insurance to allow seeing Medicaid patients, but insurance reimbursement rates are being negotiated downward, resulting in less of a buffer. Medicaid rates have not increased since 1989, while inflation has increased by 63%. She stated that more and more, physicians are choosing the business decision and not participating in the Medicaid program.

Ms. Pat McGuffy, representing the Indiana State Chiropractic Association, reiterated that costs to chiropractors have increased while Medicaid reimbursement has not. Ms. McGuffy added that reimbursement does not even cover overhead costs.

Mechanisms for Providing Health Care Coverage for Uninsured Individuals in Indiana

Ms. Carol Cutter, Chief Deputy Commissioner of Health and Legislative Affairs for the Indiana Department of Insurance, stated that under HEA 1678, two separate groups of Hoosiers will be able to purchase individual health policies if they are currently uninsured and meet the other criteria outlined in the Indiana Check Up Plan (also called the HIP plan). Individuals whose annual income is 200% or less of the federal poverty level can have premium assistance from the state, as well as $500 of preventive services at no charge. Those with income exceeding 200% of the FPL will not be eligible for a premium subsidy.

Status of 1115(b) Waiver for Healthy Indiana (HIP) Program

Mr. Mitch Roob, Secretary of the Family and Social Services Administration, provided an update of the status of the Healthy Indiana Plan (HIP). Mr. Roob stated that coverage of non-parental adults requires the approval of an 1115(b) waiver from the Centers for Medicare and Medicaid Services (CMS). Mr. Roob added that there were three outstanding issues: (1) administration of the program (e.g., CMS says the state has to use enrollment brokers), (2) the budget neutrality requirement, and (3) the CNOM issue ("Costs Not Otherwise Matchable"). Mr. Roob indicated the program is to be up and running by January 1, 2008, perhaps with a program that doesn't cover childless adults.

In response to questions, Mr. Roob stated that enrollment brokers will be specifically assigned to the larger counties.

Mr. Roob also provided an update on the tax revenue collected from the Cigarette Tax. Mr. Roob stated that the $0.44 per pack increase in the Cigarette Tax is projected to raise approximately $205 M in FY 2008, $152 M of which is to be deposited into the Check Up Plan Trust Fund. July 2007 Cigarette Tax revenues were $43 M, an increase of $14 M over July 2006. On an annualized basis, Mr. Roob stated that July tax revenues were slightly below annual projections, due primarily to a surge in purchases in May and June prior to the rate increase (see Exhibit #13).

Status of Federal Reauthorization of CHIP Program

Sec. Roob stated that HEA 1678 increased eligibility under CHIP to 300% of the federal poverty level, which would result in a potential increase in federal expenditures in Indiana of $50 million. However, if the U.S. Senate bill which would increase federal cigarette taxes by $0.61 passes, Indiana citizens would pay an additional $300 million. Sec. Roob stated that Indiana should not be a donor state in health care. He added that state legislators should contact and lobby the state congressional delegation to vote against this bill and to provide more flexibility for the state to operate and conduct its own program.

Sec. Roob added that low-income states with high numbers of smokers would tend to do poorly under this proposed bill. High-income states with low numbers of smokers would tend to do well. He added that some type of reauthorization is likely to occur this year, and the likely timeline for federal action is August or September.

Report on the Implementation of Expanding Insurance Coverage to Dependents Up to Age 24

Ms. Carol Cutter, Indiana Department of Insurance, stated that this section of HEA 1678 went into effect on July 1, 2007, and impacts individual, group, and HMO health plans. The insurers and the HMOs must include this new provision at the time the group or individual plan is renewed. This allows families to extend coverage on children beyond age 19, if not attending college, and beyond 22 or 23, if attending college, as is now the practice. The age 24 provision allows the child to be covered, when the parent or insured makes the request, to age 24 regardless of whether they are attending an institution of higher learning or not. Employer self-funded plans that are regulated by the federal Dept. of Labor under the ERISA law are exempted from having to abide by this new provision. There may also be tax consequences to the employee who asks for the extended coverage.

Most Favored Nation Clauses in Insurance Contracts

Andrew Satz, MD, Northside Anesthesia Services, LLC, thanked the members for passing legislation prohibiting "most favored nation" clauses in insurance contracts and that he wished to speak on a similar topic which also touches on the issue of unfairly perpetuating the lowest reimbursement rate among insurers: rental and silent PPOs.

Dr. Satz explained that when physicians contract to join a health plan network, the physicians usually agree to accept a reduced payment rate in return for the plan steering patients into the physician's practice. However, a "silent PPO" is when a contracting network, after negotiating discounts with providers, then sells access to the list of agreed discounts to other insurers who then, without the provider's authorization or knowledge, apply the discounts to their own payments to the provider. The practice effectively robs the physician providers of the ability to choose with whom they contract for a discount. While typically very difficult to detect, Dr. Satz's organization was able to determine that in one instance, approximately $54,000 was owed his company because of this practice.

Dr. Satz stated that the American Medical Association estimates costs to providers nationwide in the amount of $750 million to $3 billion annually. Dr. Satz also stated that not only should there be proper disclosure, there needs to be consent from the provider to lease, transfer, or sell the discount, or the provider should possess the right to opt out (or maybe some threshold number of patients under which the provider is allowed to opt out).

Ms. Elizabeth Eichorn, Indiana State Medical Association, distributed a document briefly describing rental PPOs (see Exhibit #14). Ms. Eichorn stated that doctors need to be notified when the practice is occurring, and the physicians need to be allowed to provide their consent.

Mr. Greg Yust, President of Sagamore Health Network, stated that the "most favored nation" issue is different from the "silent PPO" issue. Mr. Yust also stated that because the "most favored nation" legislation just went into effect in July, it would take several months for existing contracts to expire and for any results to show up. Mr. Yust added that "silent PPOs" don't let anyone know they exist. Mr. Yust recommended that a PPO network with whom a physician contracts provide to members cards with the PPO's identification on it.

In response to a question as to how to fix the problem, Mr. Yust stated that this would be difficult

to legislate; providers need to look at their contracts.

Other Business -

Child Protective Services Caseworkers

Ms. Anne Houseworth, Department of Child Services, updated members on Child Protective Services caseworker hiring. Ms. Houseworth stated that as of January 1, 2005, there were approximately 600 caseworkers; and as of June 30, 2007, that number had increased to 1,155. Ms. Houseworth added that there are a total of 800 new caseworkers authorized; 400 new caseworkers, net, in each of the last biennium and the current biennium.

There being no further business to consider, Sen. Miller adjourned the meeting at 5:20 pm.

The next meeting of the Health Finance Commission will be at 1:00 pm, September 10, 2007, in the Senate Chambers of the State House.